SOSM Chairperson’s Column

Renée R Jenkins-Woodard, MD, FAAP

The 2022 in-person meeting of the Leadership Conference was by all accounts tremendously successful. The plenary presentations and supportive words from the leadership were inspiring as acknowledgment of the stabilizing and recovery period we’re experiencing as the pandemic slows down. The effects of the pandemic are still with us collectively and individually and manifested very close to home for me. I arrived at Baltimore/Washington International Airport only to be told that my flight was canceled, no text message or phone call! Okay, so I was booked on a flight the next morning. Feeling a little under the weather, having attended a conference earlier in Atlanta and doing a one-day turnaround, let me do a COVID test, just in case. Not so good – POSITIVE!

Well, that blew a hole in any plans to attend the ALF. But the Section was ably represented by Whit Hall, a relatively new member of our executive committee. I’m grateful to him and for a missed flight that kept me from spreading my infection and spending five days in a hotel room in beautiful downtown Itasca!

His comments are below.

My take was like Renee’s COVID test: POSITIVE! We were all reminded of the inherent value of in-person attendance as compared to virtual. There were two overriding themes from the conference: Equity, Diversity, and Inclusion (EDI) and support for our pediatric workforce.

Regarding EDI, several excellent speakers discussed the importance of, and action steps needed for adopting EDI. There is a critical need for a focus on underrepresented populations. For example, the chance of a child dying before their first birthday is twice more among those with African ancestry than their European counterparts. And the disparities don’t stop at infancy. Homicide is responsible for more deaths than automobile accidents among all children, but those of African ancestry bear the brunt of those deaths. And the list goes on. But pediatricians don’t have to sit on their hands. Action steps are effective and doable: enhanced mentorship for underrepresented populations to get more students in the biomedical pipeline (a great way for senior members to contribute!); a research focus on eliminating disparities, especially by the NICHD (which they are now doing!); and shedding light on studies relating many diseases to race, but which upon more careful evaluation are properly related to poverty and stress. Thus, there is an urgent need to reevaluate our response to the disparities encountered in our population; pediatricians have the capacity and compassion to do just that.

Many of us have been struck by the isolation and disruption caused by COVID. And many of us have failed to recognize how severely we have been personally affected by COVID and other events (Russia’s invasion of Ukraine, climate change, economic disruption, and political divisiveness, to name a few). These invisible stressors caused unrecognized changes in our psyche. Pediatricians as a group tend to be more resilient and optimistic than most; after all, what can be more uplifting than a newborn human with all that potential?! But many have been leaving practice and suffering from burnout without realizing why. It is up to us to support each other through this time, and realize we have all been affected by the last two challenging years. Again, our group is up to the task; I know from personal experience. After facing two family tragedies, I received a lifeline of support from our wonderfully compassionate AAP family. There is no better group in the universe.

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WHAT'S INSIDE

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Thank You Whit!

Following are the top ten resolutions, which will be referred to areas of the Academy with related expertise for review and potential action:
1. Supporting Pediatrician Advocates Experiencing Adversity
2. Equitable Access to Quality Healthcare for Patients with Public and Private Insurance
3. Inclusion of Administrative Costs in Chapter Grant Opportunities
4. Expanded Education and Training on Transgender Care
5. Labeling of Sexually Transmitted Infections (STI) Screening on Explanation of Benefits (EOBs) to Support Adolescent Confidentiality
6. Alleviating Childhood Poverty Through Tax Credit Policies
7. Promote Sustainable Staffing Models for Pediatric Physicians and Their Healthcare Teams
8. Combatting Censorship: Promoting Open Access to Books and Information for Children and Adolescents
9. Improving Training for and Management of Pediatric Behavioral Health Crises in the Emergency Room Setting
10. Incorporating Environmental, Social and Governance Principles in the AAP’s Investment Strategy

For materials/presentations from the Leadership Conference go to: Leadership Conference Presentation-Handouts 2022 (aap.org)

On September 2nd our new Board members were announced. Congratulations to Benjamin D. Hoffman, MD, FAAP, President-elect and Joelle N. Simpson, MD, MPH, FAAP, At-large Board member.

Election Day is upon us! Go to “Get Out the Vote” resources from the Academy. https://www.AAP.org/votekids. Let’s get our voices heard for the children.
Editor’s Note
Gil Fuld, MD, FAAP
Editor, AAP SOSM Senior Bulletin

Welcome to the Fall issue of the Senior Bulletin. We offer the usual collection of individual reflections, personal opinions, and reports. Movie reviews and a healthy number of book reviews round out the edition. The various books look particularly interesting.

Although we did not propose a theme for the issue, and although the pandemic seems to be waning, several articles refer to it from a perspective not previously expressed. See Robert Adler’s “How the Mask Made Me a Better Doctor.” See also Michael Fuenfer’s “By Order of the President.” Perhaps other readers are as unaware of that bit of history as I was. Also new to me are the AAP’s efforts to confront climate change as outlined by Trisha Roth.

Several articles personally resonated with me. Evan Charney’s Chief’s Rounds sounds very similar to the University of Pittsburgh in the 1960s. Richard Wicklund’s motorcycle trip to Sturgis last summer reminds me of my own recent cross-country (auto) drive.

And don’t miss Lawrence Gartner’s Berlin Walk, a poignant description of his encounter with a German pediatrician.

As always comments and criticisms are encouraged. Better yet, why not contribute an article? We want to hear what you’re doing and what you’re thinking. We’re delighted to hear from such stalwarts as Paul Winick and John McCarthy, but we know we have many members with something to say.

Enjoy.

Liaison Report from the Committee on Federal Government Affairs (COFGA)
Karen Breach-Washington, MD, FAAP, Senior Section Liaison to COFGA

Awesome Advocacy and a Big Win for COFGA!

COFGA met in person in Washington, DC on September 19-20, 2022, for the first time since the onset of the pandemic.

The last meeting of COFGA was held February 7-8, 2022, and was all virtual, as was much of the work of the Washington, DC office. The opportunity to meet in person was invigorating to say the least. Day #1 revealed the advocacy successes of the past year, while day #2 was spent on Capitol Hill. National voter registration day was September 20, 2022. Vote for Children!

Much was accomplished since our last meeting, with many good things for children. The AAP was awarded $10 million over five years to fund establishment of a Center of Excellence: Creating a Healthy Digital Ecosystem for Children and Health.

Reauthorization requests from our February meeting were mostly successful. The big wins include reauthorization of funding for pediatric mental health, pediatric subspecialty loan repayment, gun violence prevention, and access to care. Other issues that were supported by the AAP and acted favorably on by Congress include: military health, immigrant health, and climate change.

Day #2 was the day to take our issues to Capitol Hill. Our focused ask was for enactment of the five-year bipartisan Jackie Walorski Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Act.

The bill passed the House Ways and Means Committee with a unanimous vote of approval the day after our visits!

Our work continues. The AAP Advocacy Conference will be held March 26-28, 2023.
Liaison Report from the
Section on Early Career Physicians (SOECP)
Elizabeth Kuilanoff, MD, MPH, FAAP

With the height of the COVID-19 pandemic behind us and a looming influenza season, early career physicians are working hard to adapt to the new normal. The Section on Early Career Physicians (SOECP) is no exception as it continues to support its members in meaningful ways.

At the AAP 2022 National Conference and Exhibition (NCE), SOECP hosted several events for early career physicians including the main program, The Leadership Continuum: Finding Individual Success, Advocating For Organizational Wellness, and Championing Diversity In Pediatrics. “As early career physicians gain leadership experience, it is important to recognize the ripple effect of their personal growth. From the individual to the institution to the field, personal growth can transcend, leading to the support, diversification, and strengthening of pediatrics.”

In addition, the SOECP selected several grant recipients as part of their Health Equity Grant Program. This program was established to support early career physicians, especially those who are underrepresented in medicine, as they conduct research, interventions, and education that address antiracism and health equity in communities and institutions. Individual projects received up to $3,000 in funding. The 2022 grant recipients and their project titles are listed below:
• Emma Anselin, MD, FAAP | Bringing Community Voice to a Medical School Curriculum for Health Equity
• Janine Bernardo, MD, MPH, FAAP | Supporting Spanish Speaking Fathers in the Neonatal Intensive Care Unit: Los padres de los pajaritos
• Gurbaksh Esch, MD, FAAP | Training Facilitators in Trauma Informed Care and Mindfulness
• Joanne Fernandez-Booker, MD, MPH, FAAP | Advancing Equity in Pediatrics
• Kamilah Halmon, MD, FAAP | Realizing Inclusion and Systemic Equity In Medicine: Upstanding in the Medical Workplace (RISE UP)
• Nikita Lindsay, MD, FAAP | Kid Doc Summer Camp
• Frinny Polanco Walters, MD, MPH, FAAP | Understanding Online Patient Portal Use Among Adolescents and their Spanish-speaking Families
• Tiffany Tucker, MD, MHS, FAAP | Ask the Doc- A Virtual Introduction to Becoming a Doctor
• Shawnese Clark, MD, MPH, FAAP | A clinical-community pediatric wellness initiative to manage and prevent cardiometabolic diseases in children with limited resources in Alabama
• Katie Wolter, MD, FAAP | Practicing Pediatricians’ Attitudes on Systemic Racism: A Mixed-Methods Exploration

Continuing their recognition of the inspiring work of early career physicians, the SOECP established three new awards: Advancement in Research Award, Excellence in Education Award, Leadership in Advocacy Award, to showcase the incredible work of the Academy’s early career physician members.

The award honorees are listed below:
• Danielle Cullen, MD, MPH, MSHP, FAAP | Advancement in Research Award
• Kimberly Montez, MD, MPH, FAAP | Excellence in Education Award
• Lisa Costello, MD, MPH, FAAP | Leadership in Advocacy Award

The SOECP continues to present webinars as part of the Leadership, Equity, and Advancement in Pediatrics (LEAP) webinar series, as well as one-time webinars providing details on Maintenance of Certification (MOC) and the AAP resolution process. All registration links and recordings are available on the SOECP members-only collaboration site. Also on the website is the SOECP Employment Support Program. This is a partnership with the AAP Section on Administration and Practice Management (SOAPM) and is intended to provide a means of supporting ECP members who are finding it difficult to secure a position for the first time or transfer to a new position. Both programs are excellent resources for early career physicians you may work with or advise to help support their careers and leadership development.
Lastly, the SOECP identified a diverse group of members for the SOECP Leadership Programming Advisory Group that will advise on the formation of a new leadership program or set of programs that align with the SOECP’s and Academy’s commitment to equity, diversity, and inclusion. The group will envision program curricula, selection processes, and accessibility through an equity lens. The goal is to leverage the success of the Young Physicians Leadership Alliance to create a new offering that is relevant and impactful for early career physicians, especially those that are underrepresented in pediatrics. They anticipate sharing plans for future programming in late 2022.

Thank you all for your continued support of early career physicians.

Advocacy

What Goes On in the Minds of Adolescent Shooters

Niru Prasad, MD, FAAP

Gun violence among our adolescents and adults has become a 21st century public health epidemic.

Recent data presented by the Centers for Disease Control and Prevention (CDC) showed the approximate number of firearm-related deaths in 2020 in the United States was close to 45,222.

Furthermore, homicides involving firearms are affecting both our adolescent and adult population in the United States. In fact, according to recent data, firearm related injuries and deaths are second only to motor vehicle accidents as a leading cause of death.

Drug overdose and poisoning increased by 83.6 percent in 2020, becoming the 3rd leading cause of death in adolescents and adults. Increasing firearm mortality in the present century reflects a long-term trend in society’s failure to protect our children.

The mass school shooting that occurred on November 30, 2021, in Oxford, Michigan, made national news. A 15-year-old school shooter killed four students and left many others injured. The shooter is being tried as an adult, and his parents have also been charged with involuntary murder.

This is a senseless tragedy.

The Oxford example is not the only example of senseless killing. Last May a young adult opened fire in a grocery store in Buffalo, New York, killing at least 10 innocent bystanders.

What are some of the factors leading our youth to violence?

Unemployment and poverty, dysfunctional families, substance abuse. Social media has also been linked to violence amongst our youth. Anxiety, depression, fear of being bullied.

Researchers are now studying “deadly dreams.” These are fantasies that young shooters frequently experience. ([www.scientificamerican.com](http://www.scientificamerican.com))

What goes on in the mind of a juvenile shooter?

Images for anatomy of the teenage brain are being performed. A thorough study of the profile of mass shooters has documented that mentally ill individuals have lower brain activity in the pre-frontal cortex of the frontal lobe (gray matter) that controls their behavior and judgment.

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Any damage to areas such as the frontal lobe, hypothalamus and limbic system, can contribute to extreme aggression, loss of control, loss of judgment and violence. Researchers have also shown that adolescents with poor impulse control, anger outbursts, schizophrenia, and abuse, are more prone to possess guns and become violent.

Research demonstrates that increased time on social media and group chatting can have a negative influence on our youth, causing a decline in mental health and making our young ones more susceptible to thoughts of suicide and violence.

Isolating alone all day and excessive use of one’s smartphone also causes loneliness and depression.

**How can we do our part to prevent mass shootings?**
- Physical and mental wellness
- Parental guidance
- School guidance
- Education
= Restrictions on access to firearms

Here in America, cycles of gun violence are exacerbated when black and brown communities are not given equal access to education, housing, jobs, mental health and trauma services. President Biden is pledging $5 billion for community violence intervention.

Protective measures to keep guns safe at home include keeping all guns unloaded and secured in a place that children cannot access.

**In conclusion:**
- Psychological evaluations can predict future psychopathic behavior.
- Gun control can help reduce senseless gun violence.
- Parents should be engaged with their children.
- Educators should be on high alerts with their students.

It is my hope that stricter gun control and good parenting will help our youth navigate through this difficult time of increased gun violence.

The views I have expressed are shaped by my 50 years of clinical practice in pediatrics and emergency medicine.

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**Global Health**

**The AAP Tackles Climate Change**

*Tricia Roth, MD, FAAP*

_Council on Environmental Health and Climate Change (COEHCC) Executive Committee, AAP Climate Chapter Advocate_

Climate is affecting child health now! A growing number of pediatricians, including some members of the AAP Senior Section, are concerned. Chapters have recognized that climate change is a growing worry among their members and patients and are stepping up climate-related advocacy in response. We are the first major medical society to create a statewide network of committed physicians working to address the problem.

Twenty-one chapters have adopted a policy statement or resolution that addresses how climate change impacts child and family health. Another dozen are considering adopting climate policies. Twenty-six chapters have climate committees, and more than a dozen have added climate issues to their legislative blueprints or websites.

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In addition, every chapter but one currently has at least one advocate participating in the Chapter Climate Advocates network. Started two years ago by climate-concerned pediatricians and the Council on Environmental Health and Climate Change (COEHCC), the program now has 120 advocates.

The chapter climate advocates hold a monthly virtual meeting to discuss efforts to advance climate action. Several advocates have formed Clinicians for Climate Action groups in their states. Many are working on medical school and residency curricula on climate, and the American Board of Pediatrics has a Maintenance of Certification module titled “Impact of Climate Change on Pediatric Health Care” thanks to efforts by the advocates.

In the past two years, climate advocates have collaborated with the Girl Scouts, art and science museums, municipalities, pharmacists, universities, pediatric environmental health specialty units and others to advance climate action. Five climate advocates serve on the Climate Health Organizing Fellows Program offered by the Center for Health Equity Education & Advocacy at Cambridge Health Alliance, and one climate advocate will champion advocacy issues with the Medical Justice in Advocacy Fellowship through the American Medical Association.

Work by advocates resulted in the American Board of Pediatrics being the first medical certifying board to offer climate and health education. A MOC 2 module, Impact of Climate Change on Pediatric Healthcare, is now available, and a MOC 4 on incorporation of climate education into office practice is forthcoming.

Two research articles provided evidence for pediatricians to address climate education with parents: (https://bit.ly/3q3CMMB; https://bit.ly/3FZzJL3). The majority of families were thankful and most believed it was appropriate.

If you are interested in getting involved, contact me at trisharoth@aol.com

Resources
• AAP Chapter Climate Advocates program
• Climate Solutions toolkit

Reflections

Tick Paralysis

Paul Winick, MD, FAAP Hollywood, FL
Retired pediatrician/Adjunct Professor of Pediatrics University of Miami

In 1966, the Vietnam war raged, and I was mustered into the Air Force. I was stationed at Keesler Air Force Base in Biloxi Mississippi to care for the children of service personnel. When Major Stowe, head of pediatrics, realized I had an interest in neurology, he allowed me to start a pediatric neurology clinic,

One day, the pediatric corpsman, Sgt. Reynolds, said, “Major Stowe asked if y’all wouldn’t mind seeing a little boy that wandered into general pediatric clinic this morning. He’s having trouble walking. Major Stowe thought you’d be interested.”

“No problem, send the family back to the examining room.”

When I walked into the examining room there was apprehension on the mother’s face. Her long hair was disheveled and the floral house dress she wore was pushed out by her burgeoning belly. Squirming on her lap was an energetic four-year-old with a mop of curly hair.

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After introducing myself, I asked, the mother, Lizzy Mae, “When did Billy start having trouble walking?”

“Let’s see, It was the day after we picked berries in the woods behind our house. That would be three days ago.”

“Has it gotten worse since?”

“At first, I thought he was being a little clumsy. You know, tripping a lot. But in the last day, he hasn’t walked at all.”

“Has he been sick at all recently?” I asked. “Just the usual runny nose.”

“Billy,” I said. “How would you like to play some games?” He smiled. “I’d like that, sir.”

“Okay, slap me five.”

He slapped out toward my extended hand, missing when I withdrew it. After three more times, our hands caressed and Billy grinned. It looked like he could move his arms well.

“Let’s see how strong you are, Billy. Squeeze my fingers with all your might.” His grip was strong, and I feigned pain. “You’re strong. Let’s play another game. I want you to pretend you’re a racing driver and step on my hand like it’s a gas pedal.”

I put my hand under his foot and could barely feel the lightness of his touch. He frowned. “You’re doing fine,” I said. Reaching over, I hugged him.

“Now I’m going to tap you with this rubber hammer to see if I can make your arms and legs jump. You’ve got to try to keep them still.”

When I tested the reflexes on his arms, they were normal, but his ankle and knee reflexes were absent. “You win the arms,” I said. “But I win the legs. We’re even.” Billy laughed.

After doing a complete exam, I asked Sgt. Reynolds to take Billy to the game room to play while I talked to Lizzy Mae.

“I’m not sure what’s wrong, but I think he has a rare neurological condition, called the Guillain-Barre Syndrome. We don’t know what causes it. The danger is that with time, the weakness will work its way upward and might even affect the muscles he uses to breathe. He should be in the hospital where we can watch him carefully.”

“How are we going to find out what’s what?” she asked, wiping her eyes.

“Children with this entity have a high protein content in their spinal fluid. I need to stick a needle in his back to collect some.”

Lizzy Mae nodded. “Okay, let’s do it.”

“I’ll come up to do the spinal tap after I’m done with clinic. Then we’ll talk some more.”

Later, I looked for Billy, who wasn’t in his room. Where was he? I walked toward the playroom. I saw Billy running in circles around his mother. When he saw me, he flew into my arms. “Let’s play slap me five again, sir.” How could he have made so rapid an improvement?

Lizzy Mae looked at me. “He’s all better. Do we still need that nasty spinal tap?” I shrugged. “Let me speak to the ward nurse.”

“What happened to Billy?” I asked the nurse. “He couldn’t move in the clinic.”

She smiled. “He was a little dirty when he reached the ward, so I gave him a sponge bath. I noticed a nasty little old tick on his neck that I pulled off with a tweezer. Maybe, that had something to do with it?”

I shrugged. I had never heard of anything like that. I grabbed a copy of the frayed pediatric text that was on the ward. In the index was the heading, “Tick Paralysis.” It was an entity I had never heard of because it was found almost exclusively in the South, and I grew

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Tick Paralysis  Continued from Page 9

up and trained in the North. The pregnant tic embeds in the body, usually the base of the neck, to feed on blood. It injects a toxin that can simulate Guillain- Barre Syndrome. Treatment and cure consist of removing the tick, which the nurse had done.

I rushed to tell Lizzy Mae that Billy was cured and wouldn’t need any tests. But I flushed with embarrassment when I told her that I never heard of tick paralysis.

She smiled. “That’s okay, Doc. We can’t expect you Yankees to know all about our Southern maladies.”

Forty Fathoms Below

Part 5: Adventures of a Squadron 7 Medical Officer

John McCarthy, MD, FAAP

After turning over the Jimmy Fish to the gold crew, we eagerly boarded our flight out of Guam to Honolulu to be reunited with our families for another three months. During this period, most sailors attended school to enhance their skills and improve their chances for promotion. As for me, I continued with Chief Lakin to hold sick call on Ford Island as I prepared to become Submarine Squadron 7’s newly qualified medical officer.

Eventually I eagerly reported for duty at Pearl Harbor as the new Squadron 7 medical officer. My office, palatial compared to the tiny one on the Jimmy Fish, included a waiting area, an office equipped with a desk, chairs and an examination table, adjacent to another medical office for Dr. R, the Squadron 1 medical officer. He had completed an internship at the San Diego Naval Hospital and planned to return there after completing his tour of duty at Pearl. I enjoyed working with him.

We covered for each other when one of us was on special assignment which took us away from out office or on leave. An important responsibility included conducting physical examinations on members of Squadrons 1 and 7 including arranging for referrals to Tripler Army Medical Center for procedures like colonoscopy and vasectomy.

We had no Hospital Corpsmen assigned to us, but a young sailor on temporary medical leave served as our “secretary”. He learned to log the patient in, obtain a brief history, and take basic vitals before being seen by me.

Most of the boats assigned to Squadron 7 were nuclear propelled fast attack subs. Only one sub was a diesel propelled boat and really cramped. Each submarine had an experienced Hospital Corpsman with a rank of E-6 or E-7 who visited me for consultation when they needed medical help. Sometimes, I even made a “house call” which gave me added insight regarding the boat’s milieu. Often, they departed for sea without notice on a “secret” mission for an unknown period. Even spouses did not know when and how long they would be gone, adding to their stress. Sometimes, I would ride on one of our subs for a day where I could get to know and help the ‘Doc’.

Once however, the corpsman on the USS Haddock, SSN 621, a Chief E-7, invited me to take a five-day one-way cruise to Bremerton to help him prepare his medical records and perform a few physical exams in preparation for their upcoming inspection. As an added treat, I experienced the boat’s prowess; diving down to 1200 feet and cruising at a high speed (referred to as “balls to the wall”); blowing main ballast; and testing their sonar system including loud pinging another sub. That was some unique experience, and I will never forget the corpsman for his kindness and calm demeanor.

On another memorable trip, I joined Dr. J’s Corpsman, an E-9 Petty Officer on a flight to San Francisco aboard a new United 747, which at that time allowed free movement up a flight of stairs to a cozy lounge. We then drove to the Mare Island shipyard to consult with Chief E-7 on the USS Permit, a 594 Nuclear Submarine (Thresher Class). He was most hospitable as we inspected his records and offered suggestions for improvement in preparation for sea trials soon after leaving Mare Island. As I recall, it was early 1973 and very chilly in Mare Island and he gave me a foul weather jacket that I still use in the winter in upstate New York.

As a squadron medical officer, I prepared myself for being called anytime. One Sunday, as I planned a drive to Bellows Beach with my wife, the phone rang. Dr J. Force Medical Officer said, “John, I need you to drive out to Barber’s Point to board a Coast Guard plane to fly down to Christmas Island where the USS Trigger (564) is moored. They have five crew members aboard who splashed a potentially caustic substance into their eyes in the aftermath of celebrating crossing the Equator, one hundred miles south of their current location.

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They were initially examined by their “doc”, treated with eye patches and placed in the boat’s wardroom rigged for dark, pending my arrival. After a smooth flight, we landed on Christmas Island where I met a local physician who I invited to join me. After boarding the Trigger, the Captain welcomed us aboard and escorted us to the wardroom where the “doc” greeted us. All five men looked like statues as they sat so still. You could hear a pin drop as they awaited their fate. One by one, we removed their patches. None looked bad. The atmosphere in the room changed dramatically to frivolity. Nevertheless, I recommended that we take all five back with us to Oahu where I would arrange for an ophthalmologist at Tripler Army Medical Hospital to conduct a thorough exam on each one. I thanked the local doctor for his assistance, and he handed me a pail of fresh local lobsters in gratitude.

Everything went smoothly after we returned to Barber’s Point and the five sailors were taken to Tripler and treated. The ophthalmologist concurred with my original assessment that there was no serious damage to their eyes.

I really loved my job as the Submarine Squadron 7 medical officer and could not believe how fast time seemed to fly. But before my tour of duty would end on June 30, 1973, the Commodore insisted that he preside over my promotion to Lieutenant Commander, Medical Corps. The attendees happily included my “Captain” for two patrols on the James Monroe, Commander William Sterling Cole, Jr. who wrote a stunningly beautiful annual evaluation (OER).

I chose to return to Colorado School of Medicine to resume my training in pediatrics despite being told that there was no room for me. I’m a fighter by nature and felt to challenge this decision. Stay tuned!

The Submarine Squadron Commander congratulates John McCarthy on his promotion to Lieutenant-Commander with his USS JAMES MONROE blue crew captain for two patrols, CDR William S Cole, looking on happily in the middle background.

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You Know More - or Less - Than You Think You Do

Bill Marshall, MD, FAAP
Professor of Clinical Pediatrics (emeritus), University of Arizona College of Medicine

In the famous opening lines (after a brief introduction) of one of the most famous “baby books” (The Common Sense Book of Baby and Child Care, New York: Duell, Sloan & Pearce, 1946), Dr. Benjamin Spock wrote to parents-to-be that “you know more than you think you do.” Was this good advice then? Is it still good advice?

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Yes, and yes. Dr. Spock’s assertion was popular - the books were best sellers - and generations of parents were helped. Of course, Dr. Spock did follow that vote of confidence and optimism with 500 pages of advice (I have my mother’s old copy, so any of my personal deficiencies are attributable to Dr. Spock), including such topics as preparing the formula (evaporated milk, granulated sugar, water, or whole cow milk, water, and granulated sugar - advising to use pasteurized milk if you can) and parenting the child who likes to listen to a lot of radio programs (“if they can afford the expense, it’s worthwhile to get him a secondhand radio for his own room”).

To consider whether “you know more than you think you do” is still a good starting point for talking with parents, it is helpful to look at what has changed in the last 80 years or so for parents and children. On one hand, families are smaller, with more single parents, and fewer young families have extended family and grandparents around, so crucial family know-how and support may be lacking. On the other hand, childhood mortality is dramatically down (infant mortality 47/1000 in 1940, 5.4/1000 in 2020) (1,2). Babies now have high rates of breastfeeding (as high or higher than the 77% rate of babies born between 1936 and 1940) (3) or drink commercially prepared infant formula. Children ride more safely in cars, play with safer toys, and are protected against many illnesses through vaccination and modern therapy. The poverty level for children (17% 2015-2020) is improved from 60 years ago (25% in the 1959-1964 period), although with unacceptable and tragic racial disparity (29% poverty rate for Black children 2015-2020) (4). In 2022, young families with new infants start in a safer and healthier place than when Dr. Spock published his book.

Do parents still know more than they think? Parents certainly are more knowledgeable in many respects, as shown by dramatic improvements in child health and safety. The internet and other media have made health advice more accessible. Unfortunately, this is a double-edged sword. Some of this information is wrong: it is not uncommon for parents to make incorrect decisions after they have done “research” online. As well, growing distrust of expertise makes it harder for sound advice to be believed.

Sometimes the inverse quote (you know less than you think you do) might be applied individually and collectively to pediatricians. I have often been humbled by seeing my predictions or diagnoses be proven wrong. I have made false assumptions about children and families: this couldn’t be abuse (the family seems nice, or the child resembles mine), they already know this (inadequate counseling of parents), I trust them to come back (lost to follow-up after a positive blood culture in urgent care). On a collective level, sometimes the advice we confidently gave parents, based on the science of the time, was incomplete, misleading, or just wrong: antibiotics for any red ear, tonsillectomy for questionable indications, cough medicines for URI, sleep monitors for siblings of SIDS, prone sleep for babies, screening vitamin D levels.

On the whole, though, “You know more than you think you do” works for both parents and pediatricians.

Confidence and optimism, along with a bit of self-doubt and a small dose of skepticism, are valuable tools for success.

References
(2) Mortality in the United States 2020 NCHS Data Brief No. 427, December 2021 Sherry L. Murphy, B.S., Kenneth D. Kochanek, M.A., Jiaquan Xu, M.D., and Elizabeth Arias, Ph.D.
This story is about Leonore, a fellow pediatrician from the children’s hospital in West Berlin, who was meeting us for lunch at Gudrun’s home in former East Berlin. Gudrun was a novelist and colleague of my wife, Carol. The lunch was to be casual and our time in East Berlin brief. Carol and I arrived in Berlin on the train from Hamburg in September 1993 and Gudrun met us to take us by the U-Bahn to her apartment. As we passed through the Friedrchistrasse U-Bahn Station, entering what had been Russian controlled East Berlin, I asked Gudrun about the shiny gold dome I noticed in the distance. That is the old synagogue, she said, which is now being restored. She added that the Friedrchistrasse Station was the connecting point on the U-Bahn between East and West Berlin and was heavily guarded with armed troops on the roof overlooking the platforms. It was here that West Berliners could enter East Berlin to visit family. I said we would like to see the synagogue if it was close enough to her place.

We got off at Alexanderplatz, walked across the park to her apartment, high-up in one of the now worn-looking Russian style buildings: gray, flat, massive. When Leonore arrived, shortly after we did, she and Gudrun immediately began an intense conversation in German which neither Carol nor I could understand aside from occasional references to “synagogue.” Lunch was served with a bit of wine, and we were then told by Gudrun and Leonore that we were going to take a walk, destination not revealed, and we did not ask. I had learned from many former foreign excursions that our hosts liked to surprise us with things we had never seen. I thought we might be going to the gold-domed synagogue.

The “walk” began with a stroll across the Alexanderplatz to the edge of the park. Leonore led us into a 19th century building with a courtyard for carriages and apartments above. Always very chatty and lively, she told us she wanted us to see a beautiful staircase. But she said nothing more about why she knew about this staircase or anything about this old Berlin neighborhood. Carol and I had met Leonore in 1966 when I was invited to speak at the annual meeting of the German Pediatric Society in West Berlin. We knew that Leonore’s mother had failed to escape from East Berlin when the Wall went up, and that they would meet in East Berlin from time to time. Leonore would bring her special foods. We also knew that Leonore had attended medical school in Berlin during World War II, but her postwar pediatric training had been in West Berlin at the Free University, where she was now Professor of Pediatrics at the Kaiserin Augusta Victoria Haus. Leonore and I shared common clinical and research interests in newborn medicine, neonatal jaundice, and pediatric history. I assumed that Leonore had grown up in what had become the Russian controlled part of Berlin since her mother was still there, but I had not asked anything more about her wartime experiences or about her mother’s life in East Berlin, nor had any more details about her early life been offered, even though we had known Leonore for more than 25 years. From our previous visits in Berlin, I knew that there were sensitive issues that many Germans did not wish to discuss with Westerners about their lives during WWII. With the revelation that Leonore knew about the “beautiful staircase”, we assumed that our walk was to take us through the part of East Berlin in which she had once lived.

Indeed, we left Alexanderplatz, walked a few blocks and entered a university campus. Leonore pointed to a grassy courtyard, telling us that her father had been killed in that courtyard by a British bomb during the war. Gudrun told us that she had been a student in this university some years after the end of the war and had met her husband there. He had been one of her professors. Leaving the university campus, walking a few blocks further on, we entered the Immanuel Church yard. Leonore pointed out her father’s grave and headstone along the wall. A few moments later a tall, middle-aged man, walking along the churchyard path, warmly greeted Leonore and they embraced. She introduced him as the minister of the church. Leonore had apparently maintained a relationship with her father’s church. She told us that her father had been founder of the church, which was built on land that had been bought from a Jewish congregation. In the negotiations, her father gave a promise to the synagogue leaders that, if he bought the land and built the church, he would “protect the Jewish community”. Walking around the beautiful courtyard, Leonore then pointed to a window in the minister’s house which she said was her bedroom when she lived there. Gudrun told us that it was in that very church that she had attended meetings in 1989 at which local people planned to tear down the Wall. Although these two women had never met before and were a generation apart, they shared common locations of importance to each of them.

Our walk in East Berlin continued toward the gold dome of the synagogue, which we could now see better, as we got closer, stopping at a courtyard surrounded by prewar apartment buildings. Leonore recalled that the Nazi SS would line up Jewish men in that courtyard in the mornings to take them away. Often a local doctor, not Jewish, would come down from his apartment and tell the SS officer that one or two of the younger men were too sick and he would take care of them. The officer would let the doctor remove them from the lineup. Leonore did not know what happened to those men, but she assumed the doctor hid them. As Leonore looked up at the six-story buildings, she commented that the people living in those apartments could see what was happening below. Across the street from the
courtyard there was a rubble-filled square between two apartment buildings where, Lenore said, a bomb had demolished one of the apartment buildings. In the postwar period the names of Jews who had been taken away and killed were painted on the bared walls of the adjacent buildings along with their occupations and dates of birth and death.

The four of us proceeded another block or two to a two-story building which had small basement windows. Leonore recalled seeing elderly Jewish women peering out at the street from those windows. Leonore led us into the building, which looked recently restored. The plaque near the door told us this was now, and probably had been in the prewar period, a Jewish community center. As we entered the reception area, much to our astonishment, several people behind the desk greeted Leonore by name and with great joy. Leonore, clearly familiar with the building, took us on a tour of the various rooms. We suddenly realized that Leonore was revealing to Carol and myself a piece of her life she had never shared with us before. She must have been a major supporter of this Jewish community in East Berlin for many years and was fulfilling the promise her father had made to protect them. He may have made some efforts, but he had died during the war.

The next part of our walk took us closer to the large, gold domed Rykestrasse Synagogue. We found a large tour with a guide talking about the synagogue and the current efforts to restore the building. We stayed for a short while, but it was late in the afternoon and Leonore needed to get us back to her house for a dinner party she had planned. We never saw the inside of the synagogue.

The next day Leonore took us to Potsdam, adjacent to Berlin, a city we had never visited on previous trips to Berlin. It was behind the Iron Curtain and the Wall until 1989 when Germany reunited. For reasons Leonore did not explain, our first stop in Potsdam was the Judenberg Cemetery, a walled Jewish burial site which contained several large tombs and many toppled gravestones, some of which were dated in the late 1930’s and early 1940’s. The cemetery was in use during the war until the Nazis closed it in 1943. Potsdam had a large Jewish population and a synagogue that was destroyed by the Nazis. A monument in the cemetery memorialized the Russian Jewish soldiers killed in World War II. There was no evidence of any effort to restore the cemetery under either Russian occupancy or, more recently, under the unified German government. Leonore also wanted us to see the remnants of the Russian military presence in Potsdam, including the areas still housing former Russian troops and their families who did not return to Russia. Potsdam in 1993 was a very worn and little-restored old city.

We left Berlin the following day with plans for Leonore to visit with us in Chicago after she gave her lecture later in the year on Professor Arvo Ylppo at the annual meeting of the American Academy of Pediatrics in Washington. Ylppo was a very famous Finnish pediatrician who spent time in Berlin at the Kaiserin Auguste Victoria Haus before and after World War II. Ylppo had also focused his research on premature infants, neonatal jaundice and breastfeeding; Leonore was recognized as his major biographer. She was also the historian of the Kaiserin Auguste Victoria Haus children’s hospital and the author of many small books about the famous hospital.

In Chicago we continued the same peculiar somewhat depressing tourism theme by taking Leonore to the just-opened exhibit of Judy Chicago’s Holocaust Project: From Darkness into Light at the Spertus Institute on Michigan Avenue. I don’t recall Leonore’s reaction to this “art show”, but Leonore, Carol and I were deeply impressed and disturbed by what the art displayed. We had never discussed anything about the Holocaust over the years, even after we recently experienced so many reminders of it. On the last day of Leonore’s visit with us, we arranged for me to take her to see the historical archive collection at the American Academy of Pediatrics not far from O’Hare Airport and then drop her off at the airport for her return to Berlin. At the beginning of the drive to O’Hare, Leonore became quiet and then said there was something important she had to tell me. The traffic was heavy, and I tried to pay attention to both Leonore and the road. The following is what Leonore said, as I recall her words:

“Early in World War II, when the Jews were being rounded up by the SS troops, my father had a knock at the door and found a couple who identified themselves as Jewish but had removed their Star of David insignia. They told my father that they had a 16-year-old daughter, close to my own age at that time, and asked him to take her into the Church House and hide her. My father said he thought about it for a brief period and then told them that he could not do that because it would put his own daughter in jeopardy. They begged him, but he did not relent. He sent them away. So, I am alive because she is dead. I have this terrible guilt.”

I don’t recall how I responded, if I did at all. I know I felt pain, the pain that Leonore felt so much more deeply. I now knew what the Berlin Walk really was all about. Leonore got out of the car, we hugged, said goodbye, and she walked into the terminal. “Terminal” was the right word for that moment. I shared the startling revelation with Carol. We often thought about it and talked about it. A few months later Leonore called, sounding less vibrant and chatty than in the past, to tell me that this was the last time we would ever talk because
she was close to dying from renal cancer, which had been diagnosed more than a year earlier. I expressed my sadness and deep loss and how much I would miss her. At that moment I also knew why the painful revelation in the car took place. She knew that was the last time she would be able to tell me in person why she “was still alive.” What I don’t know, even now, is whether I was the only person she told about her father’s decision. Maybe I was the only Jew with whom she had a close relationship and felt she had to reveal her guilt to someone. Maybe that is why I feel this obligation to share Leonore’s story with the world.

“By Order of the President...” (Part 1)

Michael M. Fuenfer, MD, FACS, FAAP Marblehead, MA

On the 27th of March 2020, the President of the United States issued Executive Order 13912, authorizing the Department of Defense to recall to active-duty status military healthcare providers, including physicians, nurses, and public health officers, from retired reserve status. In military terms, this is known as a “contingency operation”, and has only rarely been implemented on a large scale during peacetime. The COVID-19 pandemic was declared a national emergency, and medical support to the Armed Forces of the United States became increasingly tenuous, to the detriment of military readiness and national security. There were no definitive preventive measures and therapeutic medications at that time were experimental and controversial. Adding to the national sense of anxiety, recommendations from government agencies and medical authorities were conflicting and ever-changing. Hospitals throughout the United States, and worldwide, were overwhelmed with critically ill and dying patients, and a pall of fear and apprehension enveloped the country. In response, the Army sent an e-mail blast to over 800,000 medical personnel in the retired reserve database, seeking those willing and able to be voluntarily recalled to active duty for an initial period of six months. Fourteen thousand replies were received, and more than nine thousand medical providers, including over two hundred physicians, were selected to be voluntarily recalled between March 2020 and October 2021. I was one of them, and I suspect other members of the Academy were as well.

In September 2018, after 37 years of commissioned service in the Medical Corps of the U.S. Army, I had been transferred from the Active Reserve to retired status, having reached the federally mandated (Title X) age limit. Accompanying the retirement order was an American flag, an engraved certificate of retirement, and a very nice letter from the President himself, bearing a genuine facsimile of his official signature, thanking me for my service to the nation. Oh, and a lapel pin too.

Immediately following enactment of Executive Order 13912, a special administrative retiree recall office was established at the Army Human Resources Command at Fort Knox, KY. The impact of COVID-19 was especially severe in the Northeast U.S. Everything, including outpatient clinics, was locked down...tight. In mid-January 2021 the second nor’easter of the season was battering coastal Massachusetts, and outside my window the snow was piling up faster than the empty cans of energy drinks in my recycle bin. That’s when I received a phone call from a Major in the recall office who confirmed that, yes, I was still willing to be recalled, and he informed me that his office would re-contact me shortly. Due to various reasons relating to the pandemic, the Army medical department determined that there was a critical shortage of flight surgeons to support its active-duty Army aviation assets. Aviation medicine was among my military skill sets, defining an “area of concentration” (AOC), as the military refers to specialty qualifications. While not exactly my recent area of clinical practice, if that’s what was needed, I was anxious to help.

A few days later, I received an e-mail requesting submission and/or completion of over 35 various government forms and documents pertaining to my military and civilian credentials, and my willingness to forfeit military retired pay during the period of my recall to active service, etc. A few weeks after completing and submitting these reams of documents and applying for and being granted an updated security clearance, I received orders recalling me to active duty and specifying the time, date and place (Fort Carson, CO) to report. I worked my way down the list of people who I needed to notify of my impending absence, including family members, chiefs, medical staff offices, etc. The inevitable exchange went something like this -
Them: “Aren’t you a little old to be going back in the Army?”,

Me: “I’m too old for a lot of things, but I do them anyway… Bye!”

With a degree of flexibility to which I was not accustomed, the Army allowed me a couple of weeks for my report date (“Sir, if you get delayed, just let us know!”). As I departed for the 2-thousand-mile drive to Colorado, my 15-year-old car was crammed to the headliner with duffel bags stuffed with uniforms still retaining the scent of gun-oil and mothballs, assorted military equipment, three seasons of clothing, computers, books, a half-dozen binders containing civilian and military documents, cooking utensils, and everything I thought I could conceivably need. February is not the ideal time for a cross-country drive, and I encountered snow, sleet and freezing rain in all 11 states enroute. Most hotels and eating establishments were closed due to the pandemic, so I stayed at Air Force bases along my route west.

After ten days of tedious driving, along pandemic-emptied highways, traversing the frozen landscapes of the South, Midwest and Great Plains, I finally reached the front range of the Rockies, with snow-covered Pike’s Peak in the distance. Actually, the far distance, as soon became apparent. Many hours later, I finally arrived at the front gate at Fort Carson; “Best Hometown in the Army”, the sign declared. The Army loves slogans, and as slogans go, I had to admit, that one was pretty good. Why would anyone ever want to leave? I presented my military I.D. card to the MP, he saluted and greeted me with a cheery “Welcome to Fort Carson, the mountain post, sir!”.

Well, yes, I was back on active duty, and a long journey had just come to an end. What I didn’t realize at the time was, that an even longer one was about to begin.

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Chief’s Rounds

Evan Charney, MD, FAAP

Nine third-year medical students in crisp short white lab coats stood around chatting nervously at the entrance to the hospital wards. Henry, the tenth in our group was late, an unpardonable offense. We were waiting for the arrival of the chairman of the Department of Medicine. This was the most important teaching event of the week and a ritual we anticipated with dread. The first two years had been crammed with lectures and laboratory classes and we had eagerly anticipated our first clinical experience.

Each student had five or six patients on whom we had taken a complete history, performed a physical exam and followed closely throughout their hospital stay.

At precisely 8 a.m., Dr. London strode into the hall and the familiar ritual began. With the students trailing behind like ducklings, he walked briskly into the ward, plucked a chart from the rack and called out the patient’s name, “Irwin Shapiro.” Mel, the assigned student, stepped forward and began his presentation. Notes were not allowed: all was recited from memory. The Chief grilled Mel with a steady stream of questions focused on the disease - how it was diagnosed and treated, what the mechanism of the disease was and especially the underlying biochemical abnormality, if known. The questions continued until Mel and his repertoire of answers was exhausted. As chairman of medicine, Dr. L was the pride of our brand-new medical school, a physician/scientist, the model of what post-war medicine aspired to be.

After Mel’s presentation, we proceeded to the patient’s bedside. The chief introduced himself to Mr. Shapiro, who looked warily around at the group. Dr. L.’s manner was courteous but stiff. Most of the internal medicine teaching faculty were skilled clinicians, but Dr. L was more comfortable in the laboratory than at the bedside. Mr. Shapiro was recovering from pneumonia, but it was discovered that he also had a swollen scrotum. Dr. L. drew the covers back to expose Mr. Shapiro’s genitalia. “Do you know how to distinguish a hernia from a hydrocele?” he asked the group. We did not. “Ah,” he said, “let me demonstrate.” He took what looked like an empty toilet paper roll from his pocket, placed it on top of the man’s scrotum, held a penlight beneath, bent down and peered through the tube. “The light will pass more brightly through a hydrocele than a hernia,” he explained, “and so, this is undoubtedly a hernia,” he concluded.

Just then, Henry quietly tip-toed up to the back of the group. Somehow, the chief sensed his arrival. He looked up, one hand still holding the tube and the other holding the penlight, and said, “Glad you could join us, Henry. Come on forward, perhaps you can help.” Henry stared, struggling to make sense of what he saw - the chief of Medicine holding a toilet paper roll on the patient’s scrotum. He slowly

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approached the bedside, paused, looked briefly at Dr. L., and then suddenly bent down and put his ear to the tube. We gasped. There was a moment of stunned silence. Finally, Dr. L. spoke. “What do you hear?” Henry stood and then, in a confident voice, declared, “Normal testicular sounds, sir!” We burst out laughing.

Normally, this would end my story. A humorous incident if you were not Henry - or Mr. Shapiro - but I found the whole ritual of chief’s rounds troubling. The spectacle of the patient lying unclothed while the chief pontificated was humiliating for everyone. And the chief didn’t seem interested in how the patient coped with the illness but focused only on the disease. I reasoned that since the rounds were conducted by the chairman of medicine, they must represent the values the school meant to convey. It was certainly essential to learn the underlying science—medicine without science is quackery, but surely that could not be all.

I had been in the Army before medical school and the chief’s teaching-by-intimidation model reminded me of my Army experience, where officers sometimes took pleasure in humiliating the enlisted men, convinced that bullying instilled discipline.

Was I in the wrong profession?

“All you owe the patient is the right diagnosis,” one staff member remarked. You certainly owe them that, I thought, but there must be more. My next rotation was in pediatrics, and it was like night and day. The teaching faculty was no less interested in the underlying disease than were the internists, but discussions always considered how the disease affected the child and family. As one pediatrician put it, “Never refer to your patient as a ‘diabetic’ but as a ‘child with diabetes’ - the disease is not the person.” A subtle but important distinction. Caring about the patient and attention to science could be comfortably combined.

And what a joy to deal with children! Even ill, they were full of life and thankfully most recovered. They were at the beginning of their lives, rather than at or near the end.

I felt right at home. Pediatrics and I had found each other. We have been inseparable ever since.

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**How the Mask Made Me a Better Doctor**

*Robert Adler, MD, MS.Ed., FAAP*

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Halloween is a favorite holiday for many children. Dressed up in costumes for one night, they can act according to a make-believe vision that they have made for themselves. Adults play along, pretending that the imaginary person or character is the child’s real identity. At times, this even leads to parents tolerating or encouraging behaviors by their children that they might otherwise deem unsuitable.

I find some parallels between masking for Halloween once a year and masking for COVID-19 for close to two years now. Unlike children during Halloween who assume new identities by masking their faces and bodies, mandatory masking for COVID-19 has not given us a license to be someone else. What it has done is covered our facial expressions, hidden our frowns, and concealed our smiles and lip movements, forcing us to be clearer in our enunciation and our messaging.

Although the emotional, as well as the social distance has made for a very difficult year, it reminded me of how I learned to read the personality of others behind a mask, which helped make me a better physician. To connect the dots, I need to take you back to a time early in my career when I decided to seek out opportunities to be in the operating room (OR).

For me, the operating room was an unfamiliar environment with everyone working as a team, each with clear roles and expectations. The OR staff members were not necessarily appreciative of a nonsurgical pediatric faculty visitor who was not going to offer value to the surgical team. I found it to be an invaluable experience for a simple reason - surgical procedures carry significant gravity for families, and I had a busy pediatric practice in an academic medical center which generated more surgical procedures than a general practice. I knew our surgical faculty by their reputation, presentations, published papers and a few casual hallway encounters. What was missing for me was an understanding of how they treated my patients in the OR.

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I had many questions. I wondered whether the costuming of the OR, with its draping and complete obscuring of the patient in support of sterility, would mask the fact that a human person was there behind all the covers. I wondered whether the nearly virtual reality setting of the physicians and OR team, covered head to toe in masks, gowns, booties, and gloves with only their eyes visible, would change behaviors. Would it allow the surgeon to overcome inhibitions that might otherwise be in place outside the OR? What kind of person might I meet behind the masking of the OR setting that did not manifest in the hospital hallway? I was committed to finding out more and knowing who and what lay behind the mask.

It was important for me to understand this if I was going to refer my patients to them. I watched carefully how the OR team functioned under the leadership of the surgeon during tense situations. Did they accept input and suggestions from others in the OR? What kind of an environment did they create? Was the surgery smooth or chaotic? What was their surgical technique from the first incision to how they handled the tissue and internal organs under their care?

What I learned in my OR observations informed my referring practice. I made a habit of watching a surgeon perform in the OR before I felt I could make an informed decision and became more particular about the best surgical referral for my patients. I was able to give the families my confidence and reassurance about the referral I was suggesting. They were grateful to know that I had spent time in the operating room with the surgeon and could vouch for the care their child would receive. I could reassure the family that their anesthetized child would be treated with respect in the OR, and based on how they worked with their team, the surgeon would listen and answer their questions patiently.

I am grateful for what I learned from my past experiences. In the operating room, surgical masks are required, and it took trips to the operating room for me to gather an impression of the persons behind the mask. It made me examine my own “mask”, which was a collage of what others expected of me, what I expected of myself and biases that I was not always consciously aware of. Reflecting on these issues, I realized that when they did not align, it generated tension and stress in my interactions. As I became more self-aware of how this impacted on my “wellness”, I worked to understand and synthesize them to decrease differences in my internal and external expectations. This has brought me more personal satisfaction and improved my doctor-patient satisfaction and, hopefully, patients and families have felt the same.

What We're Doing Now/ Moving into Retirement and Beyond

My Trip to Sturgis or Winding Down

Richard Wicklund, MD, FAAP Lakeville, Minnesota

I left Lakeville (a Minneapolis suburb) at 10:00 a.m. on August 4th, 2022, a beautiful summer day, full of joy at age 82, for a ride across Minnesota and South Dakota. I stopped in New Ulm and had lunch with my nephew and his wife. Later that afternoon I stopped in Brookings, South Dakota at a lovely restaurant, Whiskey Creek, and the adjacent My Place Hotel. Shortly after starting out the next morning a bee flew into my right cuff and stung my forearm. I stopped in Huron and pulled out the stinger. Huron has the world’s largest pheasant. This area is noted for good pheasant hunting. Good riding in the afternoon past fields of corn and sunflowers. The temperature rose to about 90 degrees. When I arrived at the Buffalo Chip campground I slowed for other motorcycle traffic, then tipped over in coarse gravel and pulled my left hamstring muscles. Ouch! Two guys picked up my bike and rolled it through the gate down the hill into the camp. Buffalo Chip is a huge campground full of motorcycles, tents, campers and RV trailers of all kinds. It calls itself “the best party anywhere!” I found an ice cream cone and the medical tent, and got an ice pack for the back of my leg…

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I was lucky to ride into the campground and find a small patch of grass in the shade among a cluster of tents. A woman appeared and said her name was Dawn, from Portland, Oregon. She welcomed me and said I could join her group of friends from Portland. She gave me water. I unrolled my tarp and tent and promptly fell asleep. When I awoke, her friends had returned and put up my tent and offered me a chair and a beer. They re-parked my motorcycle which was perched precariously on a hillside. Instant friends! I wandered around for the rest of the day soaking up the culture of Sturgis. A small pond called bikini beach had a large rope hanging from a tree and a water slide with many people jumping in the water. I was impressed with how some huge men could climb a rope 40 or 50 feet then walk out on a large board and jump into the water making a cannonball. I found the main amphitheater where a band called “My Skillet” was playing. Later I sat in a golf cart for an hour watching the variety of motorcycles, golf carts and ATV’s going by. There are probably five or six stages with bands playing, and the bands played until 2:00 a.m. I crawled into my tent at about 10:00 p.m. and slept until about 1:00 a.m. The guys from Portland were sitting at a picnic table eating jerky and energy bars and listening to music. I joined them for a while and then wandered around some more and found a country music band that sounded good. Back in the tent from 3:00 a.m. until 7:00 a.m.

I needed to see if I could ride my motorcycle, so I started it up and rode to the other part of the campground where a church group was offering a free breakfast of pancakes and coffee. I managed to dump syrup down the front of my jacket and blue jeans. But the pancakes were delicious. As I walked back to my motorcycle there was a line of motorcycles three blocks long heading to the pancake breakfast. I got on my motorcycle and started down the road, but I had forgotten to put the kickstand up. About 10 people pointed that out to me and when I tried a quick stop I tipped over again. No further injury but I knew that any further riding would be dangerous. I went back to my campsite, said goodbye, abandoned my tent and left for home. I knew that a Harley-Davidson dealer at Exit 55 near Rapid City was buying bikes. I rode down the main street of Sturgis without buying a tee shirt, filled the tank and got on the freeway. The first exit sign I saw was 57 so I was headed home. I stopped for lunch at Kadoka and checked into a hotel for the afternoon and night. The next day I got off the freeway at Chamberlain and went north through the Crow Creek Indian Reservation. Beautiful country and no traffic. Overnight in Brookings and home the next morning. 620 miles each way. Another good adventure but it is now time to slow down.
Retirement, a Process of Letting Go

Louis Borgenicht, MD, FAAP

Retiring after 43 years of pediatrics has been an interesting phenomenon. I had a solo practice and ran my office solely with one other person. Jeri made appointments, set up patients, did the billing and (since her office was in my waiting room) chatted with patients waiting to be seen. She gathered information from them which she passed on.

I had two exam rooms and a consultation room where I ended each visit, talking about what had transpired. The room had toys for the kids, an antique rocking chair and a four-foot by six-foot collage consisting of copies of official documents (e.g., medical licenses from New York and Wyoming, diplomas from the American Academy of Pediatrics, and the American Board of Pediatrics, a letter from the President of the United States welcoming me to the Public Health Service, etc.). It covered one wall, and I considered it more intriguing than the usual black framed diplomas in most doctors’ offices. Interspersed between the documents was artwork by patients.

Of necessity I gave my own immunizations. Parents appreciated this.

I retired three years ago not being sure what the future might hold.

For a few months I worked at the Maliheh Free Clinic in Salt Lake City, but I stopped once Covid hit.

I taught a Zoom course for medical students on narrative medicine.

But I have engaged in few pediatric activities, an odd reality for having practiced every day for 43 years.

I do run into parents of patients. The encounter usually goes as follows:

Parent: “Dr. Borgenicht nice to see you.” I usually have no idea who they are.

Me: “How are your kids?”

Parent: “They are fine. One is in college. The other is teaching in Boston.”

Me: “Give them my regards.”

Parent: “I will.”

If I recognize the parents our conversation becomes more detailed and rewarding. I recall our pediatric encounters and my medical past.

My daily retirement activities have been largely conditioned by the fact that I was diagnosed with mild Parkinson’s disease in 2016. As a result, I do exercises daily and ride a Peloton bike every other day.

I am usually working on a 1,000 piece jigsaw puzzle, a pastime I consider meditative.

Thinking back over my medical life there are significant lacunae, especially concerning medical school and internship, but some cases stand out.

Working on the Wind River Reservation I cared for a four-year-old Shoshone boy with acute rheumatic fever and fulminant mitral insufficiency. I stayed up all night until we could transfer him to a government hospital in Denver.

At an HMO I saw a five-year-old with new onset leukemia. He was cured, much to my amazement. He is now a successful realtor.

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During my private practice I recall several salient patients:

- An 18-month-old with fever. He had been seen another pediatrician the day before and turned out to have Hemophilus meningitis. He is currently graduating from the University of Utah.

- A five-year-old patient of mine had a neuroblastoma. A stem cell treatment held him for three years until he had a recurrence. We had a meeting in my office with the family and a nurse who had been involved.

The family decided that they wanted him “to die peacefully at home.” I told them we could do that. For the next four months I went to 7-Eleven every Saturday and brought a Slurpee to Zach and his brother. One day Zach’s dad called and said, “I think he is going to check out.”

For the next two days I stayed at their house explaining the dying process. A funeral and wake were held a week later. Friends came from all over the country.

Many said, “You were amazing,” acknowledging my persistent involvement.

I realized that what I had done for them was nothing I had learned in medical school. In a sense I realized what it meant to be a doctor.

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**Movie Reviews**

**Fall 2022 Movie Reviews**

*Lucy Crain, MD, MPH, FAAP*

**ELVIS**

Baz Luhrmann’s new movie on the life of Elvis Presley is in most ways bigger than life, a spectacle fitting its subject. Disappointingly, the movie focuses primarily on Presley’s crooked manager, “Colonel” Tom Parker, played by fat-suited Tom Hanks as a sinister shyster (with an annoying accent).

Co-writers Sam Bromell, Craig Pearce, Jeremy Dorner and Luhrmann depict Elvis as a youngster in Mississippi exposed to the gospel and blues music of Big Mama Thornton (Shanka Dukereh) singing “That’s All Right Mama” and “Hound Dog”. As a youth, Elvis was influenced by B.B. King (Kelvin Harrison Jr.), Little Richard (Alton Mason), and others. Incorporating this background into his own style of rock and roll led him to develop dance moves offensive to most white parents and mesmerizing to youth-regardless of ethnicity.

Elvis Presley became an overnight sensation and drew the attention of “Colonel” Tom Parker, an insatiable gambler. Parker immediately saw him as his claim to fame and fortune and bound him to an irrevocable exclusive contract. In an era of racial and political unrest, Presley’s provocative gyrations in his performances provoked the ire of many and threatened to destroy his career. Parker advised him to join the Army immediately to defuse this criticism. While serving with the U.S. Army in Germany, he met his future wife, Priscilla (then 14 years old).

In the seven years between completing his tour of duty in 1960 and his wedding to Priscilla in 1967, Elvis achieved meteoric fame as the “King of Rock and Roll” and became accepted by the establishment (including President Richard Nixon). According to this script, Parker’s manipulations of Elvis’s contractual semi-enslavement to a Las Vegas hotel led to the downward self-destruction of the ”King” and his tragic death at age 42.

Music is the strength of this film with Austin Butler convincingly portraying Presley and performing most of the vocals. The only authentic vocal arrangement and archival film of Elvis is “Unchained Melody” at the end of the movie. This is one of the dozens of cinematic portrayals of Elvis and is an unsettling film in many ways. I liked Tom Hanks better as Mr. Rogers!

PG 13, 159 minutes, Budget $85 million, Great cinematography by Mandy Walker. Released to theatres June 2022 … Streaming to follow.

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*Continued on Page 22*
MRS. HARRIS GOES TO PARIS
Based on Paul Gallico’s 1958 novel of the same title, this is a pleasant bit of fluff rarely seen among today’s overly sexed, violent, super loud cinematic products. More than fairy tale fluff, there’s an entertaining plot - the story of Ada Harris, a London war widow (played by Lesley Manville) who works long hours for low wages as a housekeeper for many unappreciative clients. She falls in love with a dress designed by Christian Dior, which is a proud possession of one client (the wealthy wife of London’s “King of rubbish”) and determines to go to Paris and purchase a Dior gown of her own.

Her struggles are challenging beyond belief (including an episode where she loses her savings gambling at a dog race), but she finally arrives in the Paris salon of Dior and encounters an initially hostile new world. Isabelle Huppert, Jason Isaacs and others form a delightfully convincing cast. In lieu of explosions, gunfire and sexually explicit dialog, there are beautiful designer gowns, scenes of Paris, and the realization of a seemingly impossible dream.

Released to theatres July 15. PG I hour 55 minutes.

MY DONKEY, MY LOVER, AND I
This is another nice non-violent movie featuring lovely views of the rural Cévennes region of south-central France. Starring French actress Laure Calamy as Antoinette, a fifth-grade teacher in love with the father of one of her students. Originally, Antoinette had planned a beach vacation with her married lover but finds at the last minute that his wife has booked a Cévennes hike as a family vacation with him and their daughter. Not to be outdone, Antoinette books the same hike.

While there are other French actors of merit in the film, the real co-star is a little gray donkey named Patrick, chosen by Antoinette as her pack animal for the week-long hike in the Cévenne hillsides. Patrick becomes Antoinette’s therapist, as she pours her heart out to the patient little donkey along the challenging hike. Chance encounters and confrontations with her student, her lover and his wife predictably occur, with Patrick braying his objection to these. Our theatre audience erupted in loud laughter several times - a much-deserved and welcome reaction that we rarely experience at the movies these days.

In French with English subtitles, this comedy is playing in art theatres with limited release. Unrated (deserves an R). 97 minutes.

THE GRAY MAN
With Ryan Gosling as a CIA operative and co-starring fellow hitman Chris Evans, the film is produced and directed by the Russo brothers. I could only endure about 10 minutes of murders, explosions, and general spectacular mayhem.

Save time and money. If you must see it, it’s also available on Netflix. PG 13, 122 minutes.
Most of us did not have close clinical involvement with the SARS-CoV-2 pandemic. When the pandemic first arrived, I was prohibited from seeing potential COVID patients because of age. Later, I was a vaccinator. “The Desperate Hours” provides an unbelievably detailed picture of how the pandemic affected one hospital system, New York-Presbyterian, in the early months of the pandemic.

Brenner held hundreds of interviews with hundreds of people, patients, families, hospital frontline workers including doctors, nurses and other hospital staff, computer modelers, public health personnel and administrators. The sheer number of people may seem overwhelming, but it is not.

New York-Presbyterian is a huge system with hospitals in four of New York City’s five boroughs. It has more than four thousand beds. New York City was an early epicenter of the pandemic. New York-Presbyterian was critical in slowing the spread of the virus. Brenner writes, “Had New York-Presbyterian crumbled the damage to the nation and the world would have been many times worse than what we did experience.”

The book does an excellent job of showing how all these individuals and institutions persevered in this overwhelming event. The problems with beds, staffing, equipment from PPE to ventilators; the challenges and frustrations of treating a disease of which almost nothing was known; the toll physically, psychologically, and morally, especially on the frontline ICU staff, are all well documented. A hospital psychologist states he could not use the term PTSD: “The trauma is ongoing. This is not just post-traumatic stress disorder. This is an ongoing stress disorder.”

Beyond the physical, emotional, and moral stress, two issues stand out: The inequities in staffing, equipment, and death rates between the more affluent branches of the New York-Presbyterian system and the less affluent hospitals in the outer boroughs and lower Manhattan were significant. The lower Manhattan hospitals had a mortality rate twice that of the more affluent uptown Weill Cornell. The doctors’ call for more equitable distribution of staff and equipment went unheard.

The actions and inactions of administrators at all levels - federal, state, and within the hospital system - were egregious. Hospital reputations and personal political gain were placed before the public’s health. The Desperate Hours highlights many episodes of administrators preventing physicians, nurses, public health personnel and modelers from speaking out about the true nature of the pandemic and what frontline and public health professionals faced. Decisions made at the federal, state and hospital system level led to limited testing and limited PPE and other vital equipment. In 2005 Chang and Liang, writing in the JAMA, coined the term “administrative malpractice”, which certainly applies.

This is an important book. The stresses faced by everyone involved and the administrative errors and inequality of care are lessons that we need to carry forward to improve health care not only in pandemic times but in those non-pandemic times as well.
The Churchill Factor

Boris Johnson

Riverhead Books, 2014, 390 pages

We are familiar with Prime Minister Boris Johnson but may not know of his literary skills. He has authored poetry, fiction and non-fiction, including The Churchill Factor, an entertaining book in which he weaves a breezy narrative about war, politics and Churchill’s personal life. Starting his political career in Parliament in 1900 during Queen Victoria’s reign, Churchill retired in 1964, during the reign of Queen Elizabeth II. During this span he held every major Cabinet post, including two terms as Prime Minister, most notably during World War II when he heroically rallied Britain to stand in the way of Nazi domination. In 1940 most of Britain’s Tory leadership wanted Foreign Secretary Lord Halifax to take over as Prime Minister. Had that happened, Britain might well have worked out a deal with Hitler, because in the 1930s the average Brit was more fearful of communism than of Hitler. Johnson documents Churchill’s difficult negotiations with FDR to bring America out of its isolationist mentality and eventually support the war effort.

Johnson details Churchill’s complex relationship with his abusive father, a situation that probably led to his determination to mold his own identity. Coming from an elitist background, Churchill has rightly been accused of racist and misogynist attitudes, probably not atypical for the times. Paradoxically, while bouncing between the Liberals and Conservatives, Churchill was a strong supporter of welfare insurance, prison reform and reduction in the pension age leading some to credit him as a founder of the British welfare state.

He made major military blunders, including the battle of Gallipoli, the defense of Antwerp during WWI, and the deliberate sinking of the French fleet in Algeria during WWII. A strong believer in the “Empire,” Churchill waged a prolonged and futile campaign to keep India from gaining independence. He is credited with aiding in the formation of the State of Israel and, for better or worse, with the creation of the modern Middle East. Early on, he predicted Stalin’s push to dominate Eastern Europe, and in a 1946 speech in Missouri popularized the concept of the “Iron Curtain.” He was an architect of the “cold war strategy,” a proponent of the Atlantic Charter - a precursor to NATO - and a strong believer in a “united Europe.” Although Churchill was a strong defender of the British Empire, ironically, it was under his watch that the world saw the liquidation of the Empire and the transition of world power from Great Britain to America.

Churchill’s remarkable writing output relied on 24/7 shifts of secretaries to transcribe his speeches, political notes, correspondence and 14 original books. Churchill personally wrote every word of every speech. We recall his simple but powerful words, “Never in the field of human conflict has so much been owed by so many to so few,” memorializing the efforts of the RAF during the Battle of Britain.

As captured by Johnson, Churchill, who probably helped to save the free world, turned out to be the right leader in the right place at the right time.

Keep Sharp: Build a Better Brain at Any Age

Sanjay Gupta, MD with Kristin Loberg

Simon and Shuster, 336 pages, 2021

The well-known medical correspondent for CNN and a neurosurgeon at Emory University School of Medicine has put together a very interesting and challenging work about what current knowledge (and myths) exists about our brains and how we can strengthen and/or weaken them through our lifetimes. He has had the assistance of Kristen Loberg, a prominent writer who provides a layperson’s perspective.

Dr. Gupta approaches his subject with the typical thoroughness of a good scientist, has painstakingly interviewed hundreds of specialists

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Keep Sharp: Build a Better Brain at Any Age  Continued from Page 24

and reviewed innumerable studies in a very scholarly way to provide all of us with well-founded advice. He is so respected in this area
that in 2017 he was invited to become a member of the AARP Global Council on Brain Health.

This volume is divided into four parts:

Part 1  What is the Brain?
Part 2 Practical Strategies To Strengthen and Heighten Your Brain Function (The SHARP 12-week program)
Part 3 The Challenge of Diagnosing and Treating Brain Disease
Part 4 The Future

The references at the end are very thorough and are followed by a very user-friendly Index of most of the topics the author discusses. I
was fascinated by some of the research that Dr. Gupta presented which I had never seen before. And I also found he is open to presenting
his own skepticism and personal experience with some of the recommended steps outlined (Part 2).

I think most readers will find this a thoughtful presentation of a controversial but important subject that allows them to digest some
important information.

Book Review
Reviewed by Amar Davé, MD, FAAP

Being You
Anil Seth
Penguin Random House, 353 pages, 2021

A few years ago, the hospital quality assurance committee asked me to write a comment on the resuscitation of a newborn born with low
Apgar scores and while writing a review I inadvertently commented that the baby came out unconscious! That struck me hard enough
to ask myself a very riveting question for the first time in my career of 40-some years as a general pediatrician about the absence of the
single most important sign of life, “the level of consciousness” among the five items of the Apgar scoring system to assess the status of
newborn infant.

I searched Dr. Virginia Apgar’s original papers as well as all the papers I can put my hands on related to this matter and found none. I
went on to present a poster in Hot Topics in Neonatology regarding the missing sign of life in the Apgar Scoring system and wrote letters
to all neonatology department heads in this country to no avail.

The 2000-2001, 10th edition, Textbook of Medical Physiology by Guyton & Hall devotes less than half a page to stating that neural
mechanisms responsible for thoughts, memory and learning are not known.

“Consciousness perhaps can be described as our continuing stream of awareness of either our surroundings or our sequential thoughts.”
This has not changed in 16 years; the latest 13th edition has cut and pasted the previous one.

The Glasgow coma score was published in 1974 to objectively assess consciousness as part of a medical assessment under various condi-
tions. It has proven its utility so far.

There is yet no definitive physiologic and anatomic explanation of consciousness and with that philosophers, psychologists, neuroscien-
tists, physiologists, mystics and many more have something to say about it.

Anil Seth, a professor of cognition and computational neuroscience at Sussex University in his book, Being You, has made a significa-
cent attempt to bring the matter of study of consciousness more under the scientific domain than anyone else I am aware of. The book
addresses Giulio Tononi’s integrated information theory - level, content, and self-properties of consciousness - and comes up with a
thought-provoking conclusion of consciousness as a controlled hallucination of the perceptive world around us and within. There is
an example of how and why an octopus will not apply suction tentacles to itself because of its awareness of self. Fascinating.

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Intelligence has little to do with consciousness because none of us are willing to accept Amazon’s Alexa (artificial intelligence) has consciousness - at least for now.

The book challenges us to think of the presence of consciousness at various degrees throughout the animal kingdom. There are brilliant examples and experiments done to support or discredit age-old beliefs. Bringing Geminoids (our virtual clones) to life without being conscious. Seth quotes Schopenhauer, “Man can do what he wills, but he cannot what he will.” I think therefore I am, or I am, therefore, I think. Beast machine etc. etc.

I can only give you a taste of what I understood but this is a fascinating book looking at the matter of consciousness, often poorly understood by medical professionals like us because there is no understanding of it as of now.

**Book Review**
Reviewed by Lucy Crain, MD, FAAP

**Angel or Devil's Advocate**
*Catherine DeAngelis, MD, FAAP*
*Archway Publishing, 2022, 292 pages*

Like a Louise Penny mystery novel, this first venture into murder mystery publication by our own Catherine DeAngelis paints detailed descriptions of each of the characters in this new book (Note: see the review of the author’s previous publication Pursuing Equity… an autobiographical journey through the life of one of the most important women in medicine in the Spring 2018 issue of the *Senior Bulletin*.)

The setting is Saint Joseph’s Hospital and its surrounding community, comprised of mostly loving Italian and Irish Catholic individuals and families. It’s a calm setting, and the Saint Joseph’s Hospital where Dr. Mary Davino Defazio (the beloved “Dr. D.”) is the chief medical officer and unlike any I’ve ever encountered. The almost too-good-to-be-true heroine saves souls as well as lives and tries to solve the unexplained deaths of two patients. Cathy writes in her preface (which will greatly enhance your appreciation of the book): “I am a Catholic Christian, which is probably obvious in the story, but a reader’s faith or lack thereof should not matter in the read.”

I’ll admit that I suspected nearly all of the characters - staff and patients alike - of murdering the two patients, who were repeatedly described as being truly evil humans capable of rape, violence, fraud, theft and other crimes for which they had never been convicted. Several of the characters/suspects honestly stated that the world was better off without these two. Suspense builds and conflicts of faith, honesty and accountability emerge until the surprise ending wraps it up!

**Editor’s Note:**
Here is a blurb written by Cathy’s niece.

*Looking for a great read? Looking to support an amazing community charity? Here’s a way to do both!! Author of twelve medical textbooks and her memoir, NEPA-native Dr. Catherine DeAngelis tries her hand at fiction with her debut mystery thriller, Angel or Devil’s Advocate.*

*(All royalty proceeds of book sales will be donated to St. Joseph Center, Scranton, PA. St. Joseph’s Center is committed to the provision of joyful, loving care in its wide range of residential and community services to children and adults diagnosed with physical and/or intellectual disabilities.)*
Book Notice

Fever

Janet Gilsdorf, MD, FAAP, DSc (Hon.), FPIDS, FIDSA
Beaufort Books, 300 pages, 2022

Editor's Note: Dr. Gilsdorf, a noted infectious disease expert, presents a synopsis of her fourth book. Her previous publications include Constant Raving - A History of Meningitis and the People Who Conquered it; the novel Ten Days; and Inside/Outside: A Physician’s Journey with Breast Cancer.

In 1984, in the small Brazilian village of Promissão, a young child began to fuss, her eyes turning pink, and her skin flushed with heat. Four days later, she’s dead and other children succumb to the same illness. Sidonie Royal, an accomplished physician and scientist, discovers this outbreak on a visit to Promissão and sets about to investigate, and hopefully cure, this insidious new disease at her research laboratory in Michigan. Meanwhile, Sid’s personal life is in flux, as she struggles to balance a complicated relationship with her boyfriend, Paul; pressure to start a family from her well-meaning mother; conflict with her surly but brilliant coworker named Eliot; and a budding romantic attraction to her doctoral student’s twin brother. Set against the backdrop of the early days of the AIDS epidemic, Fever is about finding courage in the face of the unknown, the lasting power of community, and one woman’s challenge to prove herself.

Poetry Corner

The Old Captain

Tomàs José Silber, MD, MASS, FAAP Professor Emeritus
George Washington University Division of Adolescent and Young Adult Medicine

The old captain on his last voyage
silently contemplates
the waves that form and discharge in the distance.
He remembers trips made as a young man,
landscapes and adventures of the past.

The old Captain strokes his white beard
and smiles remembering a distant failure:
when wanting to sing a love serenade
accompanied by his guitar,
his voice failed him, and his fingers bled...
And despite everything
she went up to his cabin.

The old Captain dreams and grieves,
seeing at the bottom of the sea
lost comrades,
a wonderful crew,
forever young,
left behind on one trip or another.

After so many years of sailing
the ship was no longer the same,
sometimes the rudder jammed,
the ship’s original colorful paint
peeled off,
and on some occasion, she even started taking water

The old Captain has a prodigious imagination,
yet can’t see
the stormy night
in which, despite all his love,
he is going to slowly sink with his ship.

From the Archives

Editor’s note: Although this article was recently published (Senior Bulletin Summer 2019), it bears repeating, as it discusses a problem that has only been exacerbated by the COVID-19 pandemic.

Reflections on Immunization Acceptance

Edgar K. Marcuse, MD, MPH, FPIDS, FAAP

For the first time US public health is threatened by disease outbreaks due to the rejection of a vaccine by a minority of parents. In the 1970s in Europe, pertussis outbreaks followed rejection of whole cell DTP vaccine after reports of a link between DTP and encephalopathy. Then, in the UK, measles outbreaks followed rejection of MMR after the Lancet’s 1998 publication of a study by Wakefield linking MMR vaccine and autism. Around the world Wakefield’s infamous fraud served as the seed crystal around which a supersaturated solution of immunization concerns crystallized. Although these concerns were widely publicized in the US, there were few US outbreaks attributed to vaccine rejection until the Disneyland measles outbreak of 2015. Then the US began to experience sporadic measles outbreaks.

The disease was frequently imported by travelers to countries where measles remained endemic or had resurged due to a decline in immunization acceptance. At this writing US measles cases total 971 reported from outbreaks involving multiple states. The disease has occurred principally among those who are electively unimmunized, thereby prompting widespread reassessment of our immunization policies and practices.

Since the advent of smallpox immunization programs vaccine acceptance has been problematic. Indeed, the term conscientious objector first referred to rejection of smallpox vaccination. As immunization against tetanus, diphtheria, per- tussis, and polio became universal, cultural awareness among US parents of the threat constituted by these diseases gradually waned. At about the same time, the post-World- War-II confidence began to fade that science and modern medicine, which had just developed antibiotics and corticosteroids, would rapidly find solutions for other health problems. Interest in complementary and alternative medicine surged. Then trust in government and its agencies was undermined by the Vietnam War, Watergate, and recently the pharmaceutical industry’s credibility was destroyed by the Vioxx™ and Oxycontin™ scandals. These disparate threads have all been woven into and strengthened the already all-too-durable fabric of vaccine hesitancy.

Communication also changed radically as internet access grew and social media burgeoned. Presentation came to trump content; prominent vaccine deniers were given voice by well-meaning but naïve journalists seeking to achieve balance presenting a controversial issue. Evaluating the credibility of an information source became maddeningly difficult. Repetition by familiar media figures served to validate vaccine safety concerns. By 2000, 19% of US parents reported thinking vaccines were unsafe; by 2004 an impressive 94% of pediatricians reported encountering parental vaccine refusal; and by 2010 about 30% of US parents delayed or refused some vaccines.

When current science no longer informs a community’s view of a controversial issue, science illiteracy is frequently blamed. For example, those who voice doubts about the safety of universally recommended vaccines have been characterized as: “ignorant about science”,

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or of “low cognitive complexity”. But science literacy account for only a small part of how the lay public forms opinions about controversial areas such as fluoridation, genetically modified foods, global warming, or vaccines. Values, ideology, partisanship, political context, religious identity are all important influencers of our decision making. When science-based information clashes with intuitive beliefs, people resist. Even when the weight of the science is overwhelming, people continue to resist particularly when the science is complex and cannot be verified by personal experience. And the language of science is off-putting: the null hypothesis cannot be proven. When we speak science, we must say there is no evidence of an association of a vaccine with an adverse event, rather stating simply the vaccine does not cause the event.

Today’s vaccine deniers – those who proselytize their negative views about vaccines - speak science, albeit pseudoscience. They cherry pick data, cite findings out of context, develop alternative facts, suggest conspiracies to fashion arguments that seem credible, and thereby reinforce parents’ doubts and fears and legislators’ concerns. Refuting their arguments in a public venue by naming the techniques they employ to distort the truth and correcting their misinformation is no easy task even for an expert and in no way akin to communicating with a vaccine hesitant parent in a clinical encounter.

For today’s parents vaccine decision making is a challenge. They are confronted with conflicting information from their community, from the media, from various providers: what to believe is a conundrum. Eula Bliss, in her 2014 book On Immunity characterized the parents’ burden beautifully: I cast my mind ahead with each decision I make wondering what I might be giving or taking from my child in the future... But even when I do nothing I am aware, that I am irrevocably changing the future.

Multiple studies have established that a clinician’s strong recommendation is the single best predictor of vaccine acceptance. A presumptive approach – which presumes parental acceptance – has been shown repeatedly to increase vaccine acceptance compared to a participatory approach, which invites parents to voice their concerns about immunizations. But perseverance pays off: parents who initially refuse some vaccines may come to accept. Respectfully countering their arguments, raising the issue in subsequent visits, employing the motivational interviewing techniques have all been shown to be useful.

Immunization, like all public health programs ultimately depends on a broad public consensus for support. Immunization policy is informed by both science and values. What should be the balance between the state’s duty to protect the public health and an individual’s right of free choice? In other words, when does the risk to public health trump free choice? What community disease risk balanced by what assurance of vaccine safety justifies an enforced mandate? What degree of coercion in warranted?

We need to create forums in our communities where we can have a respectful, productive dialogue about how best to balance these competing values. Until we find a way to address such values conflicts, we will not be able to derive the full benefits of 21st century vaccinology.

Finance

Year-End Season of Giving

Jill Taylor, AAP Director of Philanthropy, Department of Development

The year-end season of giving is approaching and prompts many of us to consider supporting our favorite nonprofit organizations. As you think about your own charitable interests and the missions that are close to your heart, there are ways to also include the Academy in your giving.

Timely Opportunity – A gift through your IRA

Make a difference today and save on 2022 taxes. It is possible when you support the American Academy of Pediatrics through your IRA.

This is a special opportunity for those 70½ years old and older. You can give any amount (up to a maximum of $100,000) per year from your IRA directly to a qualified charity such as the American Academy of Pediatrics without having to pay income taxes on the money.

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Gifts of any value $100,000 or less are eligible for this benefit and you can feel good knowing that you are making a difference for children with a gift to AAP. This popular gift option is commonly called the IRA charitable rollover, but you may also see it referred to as a qualified charitable distribution, or QCD for short.

Why Consider This Gift?

- Your gift will be put to use today, allowing you to see the difference your donation is making.
- Beginning in the year you turn 72, you can use your gift to satisfy all or part of your required minimum distribution (RMD).
- You pay no income taxes on the gift. The transfer generates neither taxable income nor a tax deduction, so you benefit even if you do not itemize your deductions.
- Since the gift doesn’t count as income, it can reduce your annual income level. This may help lower your Medicare premiums and decrease the amount of Social Security that is subject to tax.

Estate Planning – a new online tool

Giving Docs is another way to implement your charitable giving and long-term intentions. This free online tool is specifically for estate planning. Many AAP donors have chosen to support the mission for child health in a sustainable way by providing a gift in their will. Giving Docs helps answer many questions about estate planning and offers ways to make charitable intentions official.

We are so grateful for every donor and every gift. Each one makes a tangible difference for AAP programs and especially, for children. Your generous support of programs that improve child health is essential to the mission, making life better for children everywhere.

If you would like more information about giving to the American Academy of Pediatrics, please contact Jill Taylor, Director, Philanthropy, at jtaylor@aap.org. Or visit aap.planmygift.org to learn more or donate.aap.org to make a gift.

Is Your Property Titled Correctly?

Jeff Witz, CFP®

Owning a home or purchasing an investment property are common goals for physicians, as it can be a useful tool to build wealth for themselves and their heirs. There are many ways to hold title to real property, which is defined as land, and anything built on it. However, the way in which real property is titled will affect how it is transferred during the administration of an estate after death, so understanding the differences is important.

Subject to the terminology of each state, most private residences are owned by:

- Sole owners
- Tenants by the entirety (a married couple owns property with each spouse passing it to the surviving spouse)
- Joint owners with rights of survivorship (the property is owned with another person and either party will inherit the other party’s share)
- Revocable living trust (one or more persons can own the trust)
- An entity such as a corporation, LLC or partnership
- Tenants in common (an individual owns property with another person, but the heirs of each party inherit their own share)

Each ownership method must be dealt with during the estate administration process. You need to make sure you own real estate in a way that will fulfill your wishes upon death and at the same time, streamline the process of transferring ownership of the property. Certain ownership methods can result in probate, which is a court-supervised procedure of administering a deceased person’s estate. Probate can be a long and public process and many families prefer to keep their affairs private. Estate planning techniques to avoid probate depend on how you choose to hold title to the property, but sometimes probate is unavoidable.

Sole ownership is when a property is titled in one individual’s name. That individual owns 100% of the property, with title being transferred during the probate process by direction of a Will after their death. If no Will was created, title will be transferred based on the decedent’s state of residency’s “intestate succession” laws. With sole ownership, probate cannot be avoided.

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Is Your Property Titled Correctly?  Continued from Page 30

The most common way to avoid probate if you are married is to own property as tenants by the entirety. By owning the property together, it passes to the surviving spouse outside of the probate process, avoiding delays.

Another method to avoid probate is for two individuals to own the real property jointly with rights of survivorship (do not need to be married). However, you must be careful that this option meets your wishes because you may not want the other owner to inherit your share of the property. At the death of one owner, the other owner becomes 100% owner of the property. If the goal is to pass ownership of the property to someone else, then this form of ownership may not be appropriate.

An additional way to own real property that avoids probate is with a revocable living trust. The benefit of the trust holding title to the real estate is that you can have the trust document specifically address who will inherit the property without having the need to probate the property. If a property you own has a mortgage and you want to place it in a trust, there are additional considerations. You must review the mortgage agreement, and in most cases, get pre-approval of the transfer of property. Generally, mortgage companies permit the transfer to a revocable trust.

Some owners of real property want to avoid personal liability, especially if they own commercial or rental property. These owners typically create a corporation or a limited liability company to own the real property. This provides some protection from being personally responsible for the debts or liabilities of the entity. At the time of death, these shares or membership interests in the corporation or LLC pass through the individual’s estate through the probate process. In the individual’s will, the testator (the person whose will it is) can designate who will inherit the share of the corporation or allow it to pass to the residual estate.

Holding title as tenants in common will result in the property going through probate as well. Holding title to property as tenants in common sometimes results in contention with the other owner and the individuals who will inherit your share or the other party’s share. It is best to discuss these issues with the other owner and the heirs to help alleviate any tension that may occur in the future with new ownership of the real property.

Consult your estate planning adviser about the best way to title your real property so that you have an estate plan that best meets your wishes and streamlines the transfer process upon your death.

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Gilbert Fuld, MD, FAAP Editor

Section members periodically ask for details of articles which are to be considered for publication in the Senior Bulletin. The Bulletin is published quarterly and, by popular request, are now all online but readily amenable to printing at home. Our Bulletin is not peer reviewed, nor does it strive to compete with scientific publications.

There’s an 850-word limit (with occasional exceptions) for articles to be submitted in MS Word format or double-spaced text. We welcome a wide variety of topics, including book reviews (500-word limit) and letters to the editor (350 words or less). We discourage lengthy life histories and scientific submissions which should more appropriately be submitted to peer reviewed publications. Generally, shorter is better and deadlines (published in each issue) are observed.

Submissions are not guaranteed to be posted in the Bulletin. The editor has the right to refuse publication of any article deemed inappropriate. Publication of articles may be deferred in order to reserve them for a periodic special focus issue. (Authors will be informed if this is the case.) Letters to the Editor are also sought for most issues and may relate to past articles or suggest topics of interest.

Questions about articles contemplated or in progress can be directed to me at glfuld@ne.rr.com or to Co-Editors Peter Gorski pgorski@fiu.edu and Richard Krugman RICHARD.KRUGMAN@CUANSCHUTZ.EDU. Articles and letters should be submitted to the editor at glfuld@ne.rr.com with cc to Susan Eizenga seizenga@aap.org. We look forward to hearing from you and to reading your articles in the Senior Bulletin.

2022-2024 Senior Bulletin Schedule

**Winter Bulletin - Electronic**
November 7, 2022: Call for Articles
December 12, 2022: Article Submissions Due
January 27, 2023: Bulletin Online

**Spring Bulletin - Electronic**
February 13, 2023: Call for Articles
March 13, 2023: Article Submissions Due
April 28, 2023: Bulletin Online

**Summer Bulletin - Electronic**
May 8, 2023: Call for Articles
June 12, 2023: Article Submissions Due
July 28, 2023: Bulletin Online

**Fall Bulletin - Electronic**
July 31, 2023: Call for Articles
August 28, 2023: Article Submissions Due
October 13, 2023: Bulletin Online

**Winter Bulletin - Electronic**
October 30, 2023: Call for Articles
December 4, 2023: Article Submissions Due
January 19, 2024: Bulletin Online
The Best of the Bulletin

Since its inception in 1992 the Senior Bulletin newsletter of the Section on Senior Members has been published quarterly. Since 2017, the Bulletin has been published online only. Hidden within the past issues are articles that needed to be unearthed for you, our members. We hope you find them thoughtful, memorable, entertaining, and educational. We have published an initial list of the “Best” and will add to it over time. We hope you will enjoy this new product, found here on our SOSM Collaboration Website.

If clicking on “here” above doesn’t work, here’s the link: https://collaborate.aap.org/SOSM/Pages/Newsletters.aspx?RootFolder=%2FSOSM%2FSenior%20Bulletin%20newsletter%2FBest%20of%20the%20Bulletin&FolderCTID=0x01200092B0E35AC5C1B54987AFBA9168EDA4B4&View={E73B6D0E-0A89-40C7-B9EC-AA09A2DA0B09}